| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | NVS4309AGC | A. BUILDING _____ B. WING _____ | 04/22/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ST. ANDREW CARE HOME | 1168 HACIENDA AVENUE LAS VEGAS, NV 89119 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| Y 000 | Initial Comments<br><br>The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws.<br><br>This Statement of Deficiencies was generated as a result of an annual State Licensure survey conducted at your facility on 4/22/09. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division.<br><br>The facility was licensed for eight Residential Facility for Group beds for elderly and disabled person and/or persons with mental illness, Category II residents. The census at the time of the survey was eight. Eight resident files were reviewed and three employee files were reviewed. One discharged resident file was reviewed. The facility received a grade of A.<br><br>The following deficiencies were identified: | Y 000 | Acceptable POC 5/5/09 [signature]<br><br>RECEIVED<br>MAY 04 2009<br>BUREAU OF LICENSURE AND CERTIFICATION<br>LAS VEGAS, NEVADA | |
| Y 923<br>SS=D | 449.2748(3)(b) Medication Container<br><br>NAC 449.2748<br>3. Medication, including, without limitation, any over-the-counter medication or dietary supplement, must be:<br>(b) Kept in its original container until it is administered. | Y 923 | The case worker has been notified of the error in how the delivery of medication of Resident #7 should be handled.<br><br>(cont.) nxt | |

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE [signature] TITLE OWNER. (X6) DATE 5-4-09

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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|---|---|---|---|---|
| Y 923 | Continued From Page 1<br><br>This RULE: is not met as evidenced by:<br>Based on observation on 4/22/09, the facility failed to keep medications belonging to 1 of 8 residents in their original container. Once a week, eight of eleven prescribed medications were placed in a medication minder tray by an external agency to be administered to the resident at the facility (Resident #7).<br><br>Severity: 2 Scope: 1 | Y 923 | Compliance of this procedure was met. As of April 25, 2009, All medication we received from Resident # 7 are in it's original Container.<br>Attached is a letter of the case manager of Res. # 7.<br>THE Administrator will monitor for Compliance. | |

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.